AMBULATORY SURGICAL CENTERS

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A. INTRODUCTION

The *Ambulatory Surgical Center Provider Manual* is a supplemental manual to be used in conjunction with the *Montana Medicaid General Manual* and the pink manual entitled *Completing the HCFA-1500 Claim Form*. The *Montana Medicaid General Manual*, applicable to all providers of service reimbursed by Montana Medicaid, describes rules and regulations. The *Completing the HCFA-1500 Claim Form* manual (applicable to providers which use the HCFA-1500 form including ambulatory surgical centers) discusses completion of the HCFA-1500 form. The *Ambulatory Surgical Center Provider Manual* discusses Medicaid requirements and reimbursement for ambulatory surgical center services only. All manuals are available from ACS, the Department's fiscal agent, at 1-800-624-3958 (in-state providers) or 1-406-442-1837 (Helena and out-of-state providers).

B. DEFINITION

"Ambulatory surgical center services" are services which are provided in a licensed, freestanding ambulatory surgical center. Surgical center services do not include physician services, anesthesiologist services, or ambulance services.

"Class I anesthesia risk," means an individual with no detectable systemic diseases and no physical abnormalities which would in any way impair the functioning of his/her jaw, neck, airway, chest, or abdominal function.

"Class II anesthesia risk" means an individual who has only one systemic disease which potentially threatens the safe outcome of anesthesia.

C. BENEFITS AND LIMITATIONS

1. Covered surgical procedures can only be rendered by a licensed ambulatory surgical center.

2. Ambulatory surgical center services must be provided by or under the direction of a licensed physician or, where appropriate, a licensed dentist.

3. Patients receiving ambulatory surgical center services must either be Class I anesthesia risk or Class II anesthesia risk.

4. All of the following are the conditions for coverage of listed ambulatory surgical center procedures.

   * Covered surgical procedures are limited to those procedures that do not generally exceed a total of 90 minutes operating time and a total of 4 hours recovery or convalescent time.

   * If the covered surgical procedure requires anesthesia, the anesthesia must be local or regional anesthesia, or general anesthesia of 90 minutes or less duration.

   * Covered surgical procedures may not be of a type that generally result in extensive blood loss; require a major or prolonged invasion of body cavities; directly involve major blood vessels; are generally emergent or life threatening in nature; or can safely be performed in a physician's or dentist's office.

5. Billing/payment disclaimer: The Department's goal is to pay Medicaid claims as quickly and efficiently as possible. To attain this goal, Medicaid claims are processed by computer. This automated method does not include review by medical personnel or detailed evaluation for appropriate billing procedures. Do not assume that Medicaid payment of a claim means the service was billed or paid correctly.

   The automated system detects many billing errors and denies claims accordingly. However, this process is not all-inclusive. **Providers are responsible for billing their services correctly.** Standard use of the coding conventions, particularly those established in the most current editions of the ICD-9-CM and CPT-4 manuals, are required of the provider when billing Medicaid. Providers should become familiar with these volumes as Medicaid relies on them when setting its coding policies. If providers have questions regarding definition of codes, they may be directed to the American Medical Association Health Information Services at 1-800-634-6922. There is a charge for this service.

The Department conducts periodic retrospective reviews to discover incorrect billing and payment issues. When the Department identifies a service was billed and/or paid incorrectly, federal regulations require the Department to recover the incorrect payments.

6. Medical necessity: The designated review organization and the Department's Surveillance and Utilization Review Section (SURS) conduct utilization and peer review of ambulatory surgical center services. Medicaid payments are not available for ambulatory surgical center services unless the services are considered medically

necessary. Procedures considered experimental or cosmetic are not a benefit of the Medicaid program.

7. Surgical services causing sterilization.

a. Medically necessary procedures (hysterectomy, bilateral oophorectomy, etc.)

By federal regulation, all claims for medically necessary services which render an individual sterile must be accompanied by either:

- a completed Hysterectomy Acknowledgement Form (see Addendum B, Forms)
- a copy of the operative report signed by the physician which indicates the person was sterile previous to the surgery or informed of the consequences of the surgery, or
- a letter signed by the physician stating the surgery was performed for medical reasons other than sterilization and the individual was informed of the consequences of the surgery.

These requirements apply to both male and female patients.
A notation of "Not a Sterilization" appearing on a claim is not sufficient to meet the federal requirements for payment.

b. Elective Sterilization Procedures

Elective sterilizations of male or female generally are not covered by Medicaid unless the surgery takes place not less than 30 days before nor more than 180 days after a signed consent to sterilization is obtained from the patient. **The patient must be 21 years old or older when signing the consent form**. (See Addendum B, Forms)

When submitting a claim to Medicaid for payment of an elective sterilization procedure, a completed sterilization consent form must be attached. This requirement applies to both male and female patients.

Medicaid does not reimburse for hysterectomies done primarily for sterilization purposes. However, medically necessary hysterectomies are a Medicaid covered service. Prior to a medically necessary hysterectomy, the patient must acknowledge, in writing, that the ramifications of the

hysterectomy surgery have been sufficiently explained to her.

8. Abortion Services. Abortions are a covered service of Medicaid in the three following situations when:

   a. the recipient's life would be endangered if the fetus is carried to term;

   b. the pregnancy is the result of an act of rape or incest; or,

   c. the abortion is determined by the attending physician to be medically necessary but the recipient's life is not endangered if the fetus is carried to term.

   To assure Medicaid payment for an abortion claim, a properly completed abortion certification form must be attached to each claim. (See Addendum B, Forms) One of the three sections on the form must be completed. In all situations, the name of the physician completing the procedure and his or her signature and the name of the recipient must appear on the certification form.

   For further information on the Medicaid requirements for payment of sterilizations, hysterectomies and abortions, consult the *Montana Medicaid Physician-Related Services Manual*.

D. PRIOR AUTHORIZATION

Generally, ambulatory surgical center services do not require prior authorization. However certain procedures do require prior authorization. A partial list of those procedures which MUST have prior authorization includes: reduction mammaplasty; rhinoplasty; septoplasty; penis operation to correct angulation; and corneal transplant. To determine if a procedure requires prior authorization contact ACS, the Department's fiscal agent at 1-800-624-3958 (in-state providers) or 1-406-442-1837 (Helena and out-of-state providers). If a procedure is determined to require prior authorization, the Mountain-Pacific Quality Health Foundation must be contacted at 443-4020, extension 150 (Helena) or 1-800-262-1545 extension 150 (outside Helena) to obtain authorization or the procedure will be denied.

E. PASSPORT AUTHORIZATION

PASSPORT To Health Managed Care Program

The PASSPORT Program is Montana Medicaid's Primary Care Case Management (PCCM) Program and has been very successful since implementation in 1993. The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT. All Montana Medicaid clients must participate in PASSPORT unless they are ineligible like residents in nursing homes and institutions, those with Medicare coverage, and medically needy clients with incurments. Clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." **With some exceptions, like obstetrical, all services for PASSPORT clients must be provided by or approved by the PASSPORT provider to be eligible for Medicaid reimbursement**. **For those services requiring PASSPORT approval, you must contact the PASSPORT provider and obtain approval for a specific service and document this approval by reporting the PASSPORT provider's number in field 17A on the CMS-1500 claim form to be eligible for Medicaid reimbursement.** For further information on Medicaid services that require PASSPORT approval, consult the PASSPORT To Health section of the *General Information For Providers* and *General Information For Providers II* available by contacting ACS at 1-800-624-3958 in-state or (406) 442-1837 in Helena/out-of-state.

F. BILLING PROCEDURES

1. CLAIM COMPLETION

Ambulatory surgical center services are submitted to Montana Medicaid on the CMS-1500 claim form. The CMS-1500 must be completed according to the instructions provided in the *Completing the HCFA-1500 Form* Manual, which is available from **ACS Provider Relations.**

2. TIMELY FILING

Providers shall submit a "CLEAN" claim:

a. within one year of
- the date of service,
- the date retroactive eligibility is determined,
- the date disability is determined;

OR

b. within 6 months of
- the date on the Medicare explanation of benefits approving the service, if the Medicare claim was timely filed and the recipient was Medicare eligible at the time the Medicare claim was filed;

OR

c. within 6 months of
- the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in a and b;

whichever is **LATER.**

A **"clean claim"** is one that can be processed for payment without correction, additional information, or documentation from the provider.

Date of submission is the date a claim is stamped received by ACS or the Department. A CLAIM LOST IN THE MAIL IS NOT CONSIDERED RECEIVED.

A common reason for exceeding the timely filing limit is waiting for another insurance to pay. To avoid this problem, the provider may bill Medicaid without an answer from the insurer if it has been 90 days since they billed the insurance. For further information, see *General Information for Providers* and *General Information for Providers II*.

The best method to guard against claim denial for timely filing is to establish and employ strict office procedures for claim follow-up. Follow-up procedures should include these steps:

* Always work the denied claims on the Medicaid Remittance Advice (RA).
* Correct and resubmit denied claims promptly.
* Call and ask if you do not understand a denial; **do not continue** to resubmit the same claim with no corrections.

* Call and check on the status of any Medicaid claim which does not appear on the RA within 30 days of submission date.
* Report eligibility problems to the county office as soon as they appear on the RA.
* Submit/resubmit only legible claims.
* Start a tickler file for TPL/Medicaid claims. If you haven't received a response from the other insurance at 90 days, send the claim to Medicaid with a copy of correspondence with the other payor attached.

3. MEDICARE CROSSOVER CLAIMS

The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]). Under this agreement, the carriers provide the Department with a magnetic tape of CMS-1500 (formerly HCFA-1500) claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

In these situations, providers need not submit Medicare Part B crossover claims to Medicaid. Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit.

When you receive an Explanation of Medicare Benefits from Medicare stating that your claim has been processed, and you participate in the electronic crossover process, please wait 45 days for that claim to cross over from Medicare to Medicaid before submitting that claim on paper. This allows time for the claim to cross over and be processed through our system. If your claim is submitted to Medicaid prior to the 45 day limit, it will be returned to you as soon as it is received.

When Medicaid is a secondary payor to Medicare, and Medicare has paid the claim but has not crossed it over to Medicaid, you must submit Medicare's payment amount in box 29 of the CMS-1500 form. When Medicare has denied the service, you must attach the denial, along with any explanation of the denial codes, to the claim.

4. THIRD PARTY LIABILITY

When another payor is involved, Medicaid cannot process ambulatory surgical center claims without being accompanied by either a denial or statement indicating the payment from the

relevant third party payor (TPL). If you have billed another insurance (including Medicare) and have waited 90 days with no response from them, you should bill Medicaid as follows:

Attach a note to the CMS-1500 explaining that you have attempted to bill the other insurance and the date you submitted the claim to them or a copy of the letter sent to the other insurance. Send this information to:

ACS, Inc.
Third Party Liability Department
P.O. Box 5838
Helena, MT 59604

For assistance call: Local & Out-of-State: 406-442-1837
In-State Toll-Free 800-624-3958

G. AMBULATORY SURGICAL CENTER REIMBURSEMENT

Ambulatory surgical center claims with Medicare approved procedures are assigned to a "group" within the Medicare grouper and paid at 100% of the Medicare allowable amount for rural counties. Addendum A contains the allowed procedures for Medicare at ASCs and the payment rate for each group.

For ASC services, which Montana Medicaid allows but for which no Medicare fee has been assigned, Medicaid will pay 55% of usual and customary charges.

Providers should code all services using standard coding guidelines and the rules established by the American Medical Association.

The fee for each ambulatory surgical center service group is an all-inclusive bundled payment per procedure which covers all ASC services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment and other ASC services. This includes all ambulatory surgical center services related or incident to the ambulatory surgery procedure that are provided the day before and the day of the ambulatory surgery procedure. Physician services are separately billable according to the applicable rules governing billing for physician services. Groups are determined by the CPT-4 code placed in section 24 D of the CMS-1500 form.

AMBULATORY SURGICAL CENTERS

MODIFIERS:

Multiple Procedures

When multiple procedures are performed at the same session on the same patient, the primary procedure will be paid at 100% of the customary rate. Subsequent procedures will be paid at 50% of the customary rate.

Modifiers are to be placed in the first or second slot of field 24d so that the claim will price correctly.

Bilateral Procedures

When bilateral procedures are performed at the same session on the same patient, the procedure will be paid at 150% of the customary rate.

If the procedure performed is bilateral, providers should report the procedure with one unit of service on one line with the 50 modifier. Modifiers RT and LT should NOT be billed by ambulatory surgical centers. Care should be taken not to designate a procedure as bilateral when the procedure is already identified as a bilateral service in the CPT definition. For codes defined as bilateral when a unilateral procedure is done, the procedure should be reported with a 52 modifier.

Discontinued or Reduced Procedures

The following modifiers should be used, as appropriate, for reporting discontinued or reduced procedures:

52 Reduced Services:
Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. In this case the procedure should be reported with modifier 52. Documentation should be present in the medical record to explain the circumstances surrounding the reduction in services. This modifier is also used to report codes defined in CPT as bilateral, when only a unilateral procedure is done. This procedure will be paid at 50% of the customary rate.

73 Discontinued ambulatory surgery center (ASC) procedure prior to the administration of anesthesia will be paid at 50% of the customary rate.

74 Discontinued ambulatory surgery center (ASC) procedure after administration of anesthesia will be paid at 100% of the customary rate.

Modifiers 73 and 74 should be reported when, due to extenuating circumstances or those that threaten the well being of the patient, the physician terminates a surgical or diagnostic procedure. Note: The elective cancellation of a service prior to administration of anesthesia and/or surgical prep should NOT be reported.

IT SHOULD BE NOTED THAT IN SOME INSTANCES, MORE THAN ONE MODIFIER MAY BE NECESSARY PER LINE. ALL APPLICABLE MODIFIERS MUST BE REPORTED.

ADDENDUM A

ASC Payment Rates

Group	Payment Rate
1	$295.63
2	$397.31
3	$453.80
4	$560.19
5	$638.54
6	$751.62
7	$885.96
8	$882.49*
9	55% of billed charges
10	55% of billed charges

* = $150.00 allowance for supply of an IOL is included in this rate.

ADDENDUM B

Forms

Hysterectomy Form

Sterilization Form

Abortion Form

DPHHS-MA-039
(Rev. 9/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____ *(Name of Recipient)* both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____ *(Name of Recipient)* was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

_____

_____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____ *(Name of Recipient)* was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

_____

_____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

DPHHS-MA-38
(Rev. 8/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

Medicaid Approved

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for
(Doctor or Clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____
(month) (day) (year)

I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____
(Signature) **(Date)**

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
(Interpreter) **(Date)**

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed
(name of individual)
the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is as least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
(Signature of person obtaining consent) **(date)**

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____
(Name of person being sterilized)

on _____
(date of sterilization operation)

I explained to him/her the nature of the sterilization operation _____, the fact that it is
(specify type of operation)
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At lease thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
☐ Individual's expected date of delivery: _____
☐ Emergency abdominal surgery:
(describe circumstances):_____
_____

_____
(Physician) **(Date)**

DISTRIBUTION: 1 - patient; 1 - provider (physician, hospital, etc.); 1 - fiscal agent with claim

MA-037
(REV 08/98)

MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name:_____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physicial condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an obortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

___ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or

___ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

THE INFORMATION CONTAINED IN THIS FORM IS CONFIDENTIAL. THIS INFORMATION IS PROVIDED FOR PURPOSES RELATED TO ADMINISTRATION OF THE MEDICAID PROGRAM AND MAY NOT BE RELEASED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN CONSENT OF THE RECIPIENT.